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Supreme Court to Decide on ERISA Preemption of State Law Regulating Prescription Drug Pricing

CLARISSA A. KANG

NOVEMBER 2020

One of the cases heard by eight justices of the Supreme Court (after Justice Ruth Bader Ginsburg died and before Justice Amy Coney Barrett was appointed and sworn in), *Rutledge v. Pharmaceutical Care Management Association* involves the question of whether ERISA preempts or supersedes an Arkansas state law governing prescription drug pricing for generic drugs under an ERISA health benefit plan.

The case was brought by the Pharmaceutical Care Management Association (PCMA), a national trade association representing the eleven largest Pharmacy Benefit Managers (PBMs) in the country, as a challenge to an Arkansas state law regulating pricing for generic drugs by PBMs. The case carries national significance because over thirty other states have enacted similar laws to control PBMs' pricing practices, and those state laws might be deemed to interact with ERISA health benefit plans to implicate ERISA preemption. If state law is preempted by ERISA, the state law is, in effect, not applicable to ERISA plans.

Role of Pharmacy Benefit Managers

Pharmacy Benefit Managers act as "middlemen" between health plans and pharmacies, performing services such as processing claims, calculating benefit

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IN THIS ISSUE...

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Trucker ✦ Huss Recognized in 2021 *Best Law Firms* List

Trucker Huss, APC is pleased to announce that the firm has been named a National Tier 1 firm for ERISA Litigation and a Metropolitan Tier 1 firm (San Francisco) for Employee Benefits (ERISA) Law and ERISA Litigation by U.S. News — *Best Lawyers*® "Best Law Firms" 2021 List. The firm also received recognition in the area of Employee Benefits (ERISA) Law nationally.

The 2021 "Best Law Firms" ranking showcases top firms recognized by clients and peers for delivering professional excellence and for high quality ratings. The rankings indicate a unique combination of quality in practice and legal expertise.

In addition to the firm's ranking, six Trucker Huss attorneys were recently selected by their peers for inclusion in The Best Lawyers in America© 2021:

- **Bradford Huss** — Employee Benefits (ERISA) Law and ERISA Litigation
- **Charles A. Storke** — Employee Benefits (ERISA) Law
- **Tiffany N. Santos** — Employee Benefits (ERISA) Law
- **Clarissa A. Kang** — ERISA Litigation
- **Freeman L. Levinrad** — "Ones to Watch" Employee Benefits (ERISA) Law
- **Dylan D. Rudolph —** "Ones to Watch" Employee Benefits (ERISA) Law

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levels and making disbursements, as well as generating reports and data. PBMs enter into contracts with pharmacies to create pharmacy networks. In creating their networks, PBMs may select pharmacies willing to take lower reimbursements in exchange for being placed in a preferred network, thereby potentially increasing the pharmacy's business from participants and beneficiaries of the plans to which the PBM is a service provider. When a plan participant or beneficiary presents a prescription at a pharmacy, the participant or beneficiary does not pay the full price that the pharmacist receives for the drug but instead pays a portion, or copay, and the participant's or beneficiary's health plan covers the remaining cost. PBMs gather market data to create maximum allowable cost (MAC) lists. MAC lists are used to set reimbursement rates for pharmacies filling generic prescriptions.

Arkansas PBM Law — Act 900

In 2015, the Arkansas state legislature adopted Act 900, Arkansas Code Annotated § 17-92-507, to protect independent pharmacies, including those serving rural areas, in part from PBMs' pricing practices that affected the profitability of pharmacies, particularly with regard to generic drugs. Act 900:

- Requires pharmacies to be reimbursed for generic drugs at a price equal to or higher than the cost invoiced for the drug by the wholesaler to the pharmacy;
- Requires PBMs to update their MAC lists within at least seven days from the time there has been a certain increase in the costs of acquiring the generic drugs;
- Provides pharmacies with administrative appeal procedures that allow a pharmacy to reverse and rebill claims affected by a pharmacy's inability to procure the drug at a cost that is equal to or less than the cost on the relevant MAC list where the drug is not available "below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale"; and
- Provides a "decline-to-dispense" option for pharmacies to decline to fill a prescription where the transaction would result in the pharmacy losing money.

Challenges in the District Court and Circuit Court of Appeal

PCMA initially challenged the Arkansas law, Act 900, on the basis that it is preempted by ERISA and Medicare Part D and that it violates the U.S. Constitution and the Arkansas Constitution.

On motions for summary judgment, the U.S. District Court for the Eastern District of Arkansas held that Act 900 was preempted by ERISA as applied to ERISA plans but otherwise withstood the challenges PCMA brought as to its constitutionality and preemption by Medic are Part D. PCMA appealed the ruling on the lack of preemption under Medicare Part D. The Arkansas State Attorney General appealed the ruling on ERISA preemption.

Eighth Circuit Holds Arkansas Law Is Preempted, Based on Precedent

On appeal, the Eighth Circuit Court of Appeals, held that Act 900 was preempted by both ERISA and Medicare Part D.

Like the District Court, the Eighth Circuit looked to the Eighth Circuit's 2017 ruling in *Pharm. Care Mgmt. Ass'n v. Gerhart*, 852 F.3d 722 (8th Cir. 2017), which held that an Iowa PBM law that had a similar purpose and effect as Act 900 was preempted by ERISA because it had a prohibited reference to ERISA and interfered with national uniform plan administration. The Iowa law required PBMs to provide information regarding their pricing methodologies to Iowa's insurance commissioner upon request. It limited the types of drugs to which a PBM could apply MAC pricing and limited the sources from which a PBM could obtain pricing information. In addition, it required PBMs to provide their pricing methodologies in their contracts with pharmacies and to provide procedures by which pharmacies could comment on and appeal MAC price lists or reimbursements. The Eighth Circuit ruled that the Iowa law had both an impermissible express reference to ERISA and an implicit reference to ERISA through regulation of PBMs who administer benefits for ERISA plans.

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In *Rutledge*, the Eighth Circuit held that *Gerhart* dictated how the court must rule — that ERISA preempted Act 900. The court held that Act 900 both relates to and has a connection with employee benefit plans and is therefore preempted. The State of Arkansas sought Supreme Court review.

Supreme Court Review

The Supreme Court accepted review of Eighth Circuit's ruling that Act 900 was preempted. After postponement earlier this year, the Court heard oral argument last month, after Justice Ginsburg had passed away, but before Justice Barrett was confirmed. Justice Barrett, barring any recusal, will participate in deciding the case. Oral argument occurred on October 6, 2020, as one of the cases heard via telephone by the Court during the pandemic.

Arkansas argued that the Eighth Circuit improperly expanded ERISA preemption in that ERISA ordinarily does not preempt state rate regulation, and Act 900 qualifies as state rate regulation. The state argued that when ERISA plans are purchasing goods or services for the purposes of providing benefits to their participants and beneficiaries, they are acting like any other consumer in the marketplace and, as such, are subject to market regulation. Arkansas relied heavily on the Supreme Court's decision in *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., 514 U.S. 645, (1995), which upheld a New York law requiring hospitals to add a surcharge on patients with certain types of insurance rates, in which the Court stated, "ERISA was not meant to pre-empt basic rate regulation." *Id.* at 667 n.6. Arkansas argued that Act 900 regulates drug reimbursement rates and provides mechanisms for enforcing that rate regulation, including requiring PBMs to provide pharmacies with internal appeals to challenge rates and the option to decline to dispense drugs if the reimbursement rate set by the PBM is below a certain cost threshold. Arkansas also argued that ERISA preemption is not implicated because Act 900 does not regulate claims processing — because resolving a pharmacy's reimbursement dispute is not a step in processing a health plan beneficiary's claim. According to Arkansas, the claims processing function of PBMs is complete before any ERISA plan participant pays the pharmacy co-pay — and the reimbursement paid to a pharmacy through a PBM does not affect what part or percentage the participant pays (because that is set by the plan document and determined before any reimbursement dispute between the pharmacy and the PBM). Arkansas takes the position that Act 900 does not regulate prescription drug benefits and therefore does not trigger ERISA preemption.

The U.S. Solicitor General argued in favor of Arkansas — i.e., that Act 900 was not preempted by ERISA because it affected only the reimbursement to pharmacies by PBMs (as third-party administrators of plan benefits), and such reimbursement between the PBMs and the pharmacies was not a matter central to ERISA plan administration.

PCMA argued for ERISA preemption in that Act 900 does not regulate rates for goods and services in the marketplace — it is silent as to pharmacy pricing, never directly stating that pharmacies get $X for Y drugs — and instead erects procedures that affect plan administration and erode national uniformity. Addressing the arguments made by the United States that preemption applies only when the state law directly affects plan management and not when the law only affects the PBM as a third-party administrator, PCMA argued that there was no distinction, for ERISA preemption purposes, between PBM administration and ERISA plan administration. PCMA asserted that Act 900 establishes state-specific rules controlling the amount plans must pay for benefits, the methodology for determining that amount, the timing and procedures for updating payment schedules, and dispute-resolution processes and remedies — all of which are matters central to plan administration. According to PCMA, Act 900's decline-to-dispense provision was particularly problematic in that it controls whether plan participants will receive benefits promised under their plans. Addressing Arkansas' reliance on Court precedent in *Travelers*, PCMA pointed out that *Travelers* implied that preemption was appropriate if the state law produces economic effects (even indirectly) that force an ERISA plan to adopt a certain scheme of coverage or binds plan administrators to particular choices such that the law functions as a regulation of plan administration itself. PCMA argued that Act 900 was such a regulation impacting the plan itself.

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Oral Argument at the Supreme Court — Hard to Predict Outcome

At oral argument on October 6, 2020, the justices seemed to ask questions challenging both sides, and it is difficult to predict how the Court will decide the case. Notably, Chief Justice Roberts commented that it was not the fault of Arkansas or the pharmacies that "PBMs have such byzantine procedures that affect drug prices" — a comment which might suggest that the state law has a purpose worthy of being upheld. Several justices (including conservative justices) asked questions on the issue of costs and impact on benefits — specifically, whether Act 900 increased drug costs for employee benefit plans and participants, and whether that triggered ERISA preemption. The justices also asked about the scope of ERISA preemption, particularly in light of the Court's 2016 decision in *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016), which held that ERISA preempted a Vermont law that required plans to report to a state health claims database — i.e., if reporting related to health plans triggered ERISA preemption, wouldn't legislation affecting payment for prescription drugs do so, too, as paying for prescription drugs would seem to be a central function of a health plan? Answering a question from Justice Gorsuch, Arkansas Attorney General Nicholas Bronni answered that the situation was different from *Gobeille* in that while ERISA has specific reporting and recordkeeping provisions with which the Vermont law conflicted, there are no ERISA provisions that govern what Act 900 does — a dispute between a third-party administrator and service provider, or between a plan and a service provider.

If the Court affirms the Eighth Circuit's decision holding that Act 900 is preempted, the ruling could have broad application beyond Act 900 and could result in challenges to state laws governing PBMs in the approximately 40 states that have adopted such legislation. A Supreme Court ruling in *Rutledge* could even effect change in ERISA preemption jurisprudence for state laws other than ones regulating PBMs. The case presents an opportunity for the Court to revisit its ERISA preemption decisions, particularly *Travelers* and *Gobeille*, to provide more details on when state law is preempted by ERISA.

FIRM NEWS

On October 6, **Joe Faucher** and **Dylan Rudolph** presented a webinar for the National Center for Employee Ownership regarding collateral payments in ESOP transactions. The webinar addressed recent cases, focusing on transactions in which company stock is sold to third-party buyers and challenging the propriety of collateral payments (such as retention bonuses and non-compete payments) to officers and directors of the ESOP-owned company.

On October 21, **Charles Storke** participated in a presentation to the Annual Meeting of the Conference of Consulting Actuaries, *Multiemployer Funding Legislative Update*.

On October 30, **Joe Faucher** presented *Nightmare on Benefits Street* as part of a panel discussion at the Western Pension & Benefits Council's October chapter meeting.

On November 13, **Sarah Kanter** was appointed as a Vice Chair for the American Bar Association Health Law Section's Cancer Legal Advocacy group.

On November 18, **Katuri Kaye** was recognized as the *Leader in Law* in the Employment and Labor Law category by the Los Angeles Business Journal. Congratulations, Katuri!

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Keeping COBRA Notices Compliant in an Ever-Changing Landscape

JAHIZ NOEL AGARD

NOVEMBER 2020

2020 has presented several issues requiring urgent attention for employers who sponsor group health plans, including a need to update the notices required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), in particular the general (or initial) notice and the continuation coverage election (or enrollment) notice. This article will describe what employers should keep in mind while updating their COBRA notices, including (i) recent revisions to the Department of Labor's (DOL's) model COBRA notices in May 2020, (ii) the mandatory extensions to certain COBRA-related deadlines due to the COVID-19 pandemic, and (iii) the allegations in the many class-action lawsuits filed over the last few years alleging deficiencies in COBRA notices.

Required COBRA Notices and the Model DOL COBRA Notice

The 2004 COBRA regulations describe certain notices that the "administrator" of an applicable group health plan[1] are required to provide employees and/or qualified beneficiaries. The two most important of these notices are the general (or initial) notice and the election or (enrollment notice).

Under the COBRA regulations, the administrator must provide each covered employee and spouse (if any) with a general (or initial) notice at the time coverage under the plan begins.[2] The general notice is required to include six information items including, a general description of COBRA continuation coverage, when it may become available, and what needs to be done to protect one's right to receive such coverage, among other things.[3]

The COBRA regulations also require administrators to provide election (or enrollment) notices to qualified beneficiaries (i.e., those individuals who have a right to elect COBRA continuation coverage).[4] The election notice must include fourteen information items, including the procedures to elect coverage, the cost of the coverage, the duration of the coverage, and events which may cause the coverage to terminate early, among other things.[5]

Both the general notice and election notice must be "written in a manner calculated to be understood by the average participant." The COBRA regulations also include, in separate appendices, a model general notice and a model election notice (and the latter includes a model enrollment or election form). Under the regulations, group health plans are not required to use the model notices; however, use of the model notices, "appropriately modified and supplemented" to reflect the applicable plan terms and contact information, will be deemed to satisfy the notice requirements.

In 2014, the DOL issued proposed regulations to amend the notice requirements. The proposed regulations included removing the appendices with model notices from the regulations in order to facilitate updates to the model notices (which could then be posted to the DOL's website instead of amending the regulations every time the model notices are updated). Concurrent with issuing the proposed regulations, the DOL provided updated model notices which explain to qualified beneficiaries that if they lose job-based health insurance coverage, they may pursue coverage through other avenues, such as the Health Insurance Marketplace (also known as the Health Insurance Exchange), Medicaid, or another group health plan (e.g., a spouse's plan).

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May 2020 Updated Model Notices

On May 1, 2020, the DOL provided further updated model notices and responses to some frequently asked questions (FAQs). In introducing the updated model notices, the DOL included a reminder that in order to use these model notices properly, the "Plan Administrator must fill in the blanks with the appropriate plan information." The DOL provided the updated model notices in both English and Spanish.

The prior model notices did not address the interaction between Medicare and COBRA. For individuals who qualify for both Medicare and COBRA continuation coverage, there are several factors to consider in deciding whether to elect only one type of coverage or both. Although Medicare is generally less costly than COBRA, an individual covered under an employer-sponsored plan and in the midst of receiving certain medical treatments may want to decline Medicare and elect COBRA coverage to retain the services of their current physician and hospital facilities. However, declining Medicare when one is first eligible for Medicare may result in higher Medicare premiums in the future.

The updated model notices and FAQs include explanations on the interaction between Medicare and COBRA, as follows:

1. A Medicare-eligible qualified beneficiary may enroll in Medicare instead of electing COBRA continuation coverage after the group health plan coverage ends.

2. In general, if a Medicare-eligible individual does not enroll in Medicare Part A or B when first eligible because he or she is still employed, he or she has an 8-month special enrollment period to sign up, beginning on the earlier of (a) the month after employment ends, or (b) the month after group health plan coverage based on current employment ends.

3. If a Medicare-eligible qualified beneficiary does not enroll in Medicare Part B and elects COBRA continuation coverage instead, he or she may have to pay a Medicare Part B late enrollment penalty and may have a gap in coverage if he or she wants to enroll in Medicare Part B later.

4. If a Medicare-eligible qualified beneficiary first elects COBRA continuation coverage and then later enrolls in Medicare Part A or B *before* COBRA continuation coverage ends, then the plan may terminate COBRA continuation coverage early.

5. If a Medicare-eligible qualified beneficiary becomes entitled to either Medicare Part A or B (i.e., becomes eligible and enrolled under Medicare, on or before the date of the COBRA election), COBRA coverage may not be discontinued on account of Medicare entitlement, even if he or she enrolls in the other part of Medicare after the date of the election of COBRA coverage.

6. If a Medicare-eligible qualified beneficiary is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second.

For more information on the interaction between Medicare and COBRA, the model notices direct the reader to the following website: https://www.medicare.gov/medicare-and-you.

Extended COBRA Deadlines

On April 28, 2020, a few days before providing the updated model notices and FAQs, the DOL, along with the Department of the Treasury and the Internal Revenue Service, issued guidance providing COBRA qualified beneficiaries with extended deadlines to elect continuation coverage and to pay the premiums associated with such coverage (the Joint Notice).

Under COBRA, a qualified beneficiary has 60 days from the date group health plan coverage terminates or, if later, 60 days after the date of their COBRA election notice to elect COBRA continuation coverage. Once qualified beneficiaries elect COBRA coverage, they have 45 days to make their initial COBRA premium payments. Subsequent premium payments must be made within the 30-day grace period that starts at the beginning of each coverage

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month (i.e., within 30 days after the due date for that coverage month).

The Joint Notice extends the above deadlines by disregarding any days in the "Outbreak Period," i.e., the period from March 1, 2020 until 60 days after the announced end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (the "National Emergency") (or other date announced by the applicable federal agencies in a future notification). For more information on these deadline extensions, see our newsletter article, COBRA, HIPAA Special Enrollment, Claims and Appeals, and ERISA Notice Related Deadlines Extended.

The May 2020 updated COBRA model election notice does not include any reference to the extended deadlines provided by the Joint Notice. Instead, the model notice refers to the normal deadlines (i.e., 60 days for electing coverage, and 45 or 30 days for paying the premiums, as applicable). To avoid confusion and possibly minimize future litigation, employers should include information regarding the extended deadlines within (or along with) the COBRA election notices sent to qualified beneficiaries while the National Emergency is still in effect. Instead of updating the election notice itself to reflect these extended deadlines, many plan administrators and COBRA administrators have included a description of these extended deadlines in a separate document enclosed with the COBRA election notice.

Recent COBRA Notices Litigation

In the last four years, increasing numbers of employers have been sued by former employees alleging that they received defective COBRA notices. Over the last two years, in particular, such lawsuits have been initiated against the following household-name employers: Home Depot, Target, Starbucks, Southwest Airlines, Best Buy, The Hershey Company, Coca-Cola Beverages Florida, Nestle Waters North America, and Amazon.

Typically, this litigation involves class action lawsuits and former employees who did not elect COBRA coverage and then subsequently incurred significant costs for medical treatments while uninsured. The lawsuits generally focus more on the election notices than on the general notices. The plaintiffs typically allege that the actual election notices deviated from the DOL's regulations, resulting in (i) the notices being misleading to qualified beneficiaries; (ii) the qualified beneficiaries having insufficient information to make informed decisions regarding COBRA coverage; and (iii) the qualified beneficiaries failing to enroll in COBRA coverage to their detriment.

The alleged defects in the COBRA election notices generally include one or more of the following:

- Omission of the qualifying event permitting an election of continuation coverage (e.g., termination of employment, reduction in work hours, death of employee, divorce);
- Omission of the COBRA enrollment or election form;
- Omission of the plan name;
- Failure to sufficiently identify the plan administrator;
- Failure to include the address indicating where the COBRA premium payments should be mailed;
- Failure to provide the date on which, if elected, COBRA continuation coverage will begin;
- Failure to include information on how COBRA coverage can be lost prematurely (e.g., because of late premium payments);
- Failure to provide an explanation of the maximum period for which COBRA coverage will be available;
- Failure to provide the notice "written in a manner calculated to be understood by the average participant"; and
- Conflicting information on when the COBRA enrollment or election form is due.

So far, no court has ruled on the merits of any of these recent lawsuits; however, some employers have chosen to settle. Guidance from the DOL would be helpful here. For example, the regulations do not require that the notices be issued in foreign languages. Nonetheless, one may argue that if a significant number of plan participants are fluent in Spanish only, a notice written in English only is not "written in a manner calculated to be understood

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by the average participant." The DOL has not provided guidance addressing this or other issues raised in these lawsuits.

However, on October 5, 2020, the DOL filed an amicus brief in the case, *Carter v. Southwest Airlines Co. Board of Trustees*.[6] In that case, the plaintiff alleges that the COBRA election notice did not comply with the DOL's regulations in part because the election notice excluded contact information for Southwest Airlines as the plan administrator. Southwest Airlines argues the notice included the name, address and phone number of the party responsible for COBRA administration (i.e., a third-party administrator). In its brief, the DOL asks the court to rule that the regulations do not require COBRA election notices to include the contact information for plan administrators where a different entity administers the plan's COBRA continuation coverage. This amicus brief suggests that the DOL may not be receptive to allegations that require a hyper-technical reading of the COBRA notice regulations; however, it's just one example. We will closely watch the progress of this and other lawsuits, and hope more guidance is forthcoming from the DOL.

Next Steps

Employers should carefully review their COBRA notices to ensure compliance with the regulations, preferably through use of the DOL's model notices with appropriate modification and supplementation to reflect the applicable plan terms and contact information. Until the National Emergency ends, employers should also make sure that qualified beneficiaries are notified of the extended deadlines to elect continuation coverage and pay the premiums.

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[1] The requirements for COBRA continuation coverage do not apply to group health plans maintained by (i) churches; (ii) governmental entities of the U.S., Washington, D.C., and U.S. territories and possessions; (iii) state and local government agencies which do not receive Public Health Service Act funding; and (iv) small employers (i.e., generally, employers with fewer than 20 employees).

[2] *See* 29 C.F.R. § 2590.606-1.

[3] *See* 29 C.F.R. § 2590.606-1(c).

[4] *See* 29 C.F.R. § 2590.606-4.

[5] *See* 29 C.F.R. § 2590.606-4 (b)(4).

[6] Brief for Secretary of Labor as Amicus Curiae, *Carter v. Southwest Airlines Co. Board of Trustees* (M.D. Fla. 2020) (Case No. 8:20-cv-01381-WFI-JSS).

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Notice 2020-79 (in case you missed it...)

There were not many changes in the limits for 2021. In fact, the only key changes were for the compensation that is to be taken into account for purposes of determining plan benefits, and the maximum amount that can be contributed on behalf of a participant in a defined contribution plan (such as a 401(k) plan). The limits for 2021 are as follows:

	2021	2020	2019
401(k)/403(b)/457 Elective Deferral Limit	$ 19,500	$ 19,500	$ 19,000
Defined Contribution Plan Annual Limit	$ 58,000	$ 57,000	$ 56,000
Defined Benefit Plan Annual Limit	$ 230,000	$ 230,000	$ 225,000
Annual Compensation Limit	$ 290,000	$ 285,000	$ 280,000
Catch-Up Contribution Limit	$ 6,500	$ 6,500	$ 6,000
Highly Compensated Employee Compensation Threshold	$ 130,000	$ 130,000	$ 125,000
Key Employee Compensation Threshold	$ 185,000	$ 185,000	$ 180,000

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In response to new IRS rules of practice, we inform you that any federal tax information contained in this writing cannot be used for the purpose of avoiding tax-related penalties or promoting, marketing or recommending to another party any tax-related matters in this *Benefits Report*.

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